

to be used, but if resistance is great force is dangerous. The smallest bougie is then to be made to carry a heavy braided ligature silk from the stomach to the mouth. A larger bougie is now passed from the stomach alongside the string and pressed tightly into the stricture, so as to stretch it. The string is now drawn upward by the fingers introduced well back in the mouth, and the bougie will be felt to advance at once as the string wears away the tense stricture. Larger bougies are now pressed in and the string see-sawed back and forth. When the largest size has been attained a corresponding rubber tube is drawn up the œsophagus past the point of stricture, its lower end remaining outside the stomach wound. A smaller tube is introduced into the stomach for nourishment. The patient can thus drink water for refreshing the mouth, or swallow saliva without contaminating the wounded surface, which the tube also serves to keep dilated. The large tube may be removed the second or third day, and dilating bougies introduced from the mouth after the fourth day. The gastrostomy wound may be closed by a plastic operation whenever the patient has gained strength.—*Medical Record*, February 25, 1893.

II. The Closure of Cut Throat and Surgical Wounds of the Air Passage by Immediate Suture. By HENRY MORRIS, M.B., LOND. (London). The author departs from the approved methods of leaving cut throat wounds to heal by granulation and cicatrization, and seeks by the liberal employment of buried and superficial aseptic sutures to bring about immediate union. He takes great care, after thoroughly cleansing all the parts about the wound, to unite accurately, end to end, the cut edges of each structure which has been divided—cartilage with cartilage, membrane with membrane, muscle with muscle, fascia with fascia and skin with skin. He also inserts a few pieces of drainage tube at selected points of the wound, and by these means provides against the sources of danger ordinarily attributed to immediate suture, such as suffocation from recurrent hæmorrhage or purulent discharges into the air passages, inflammation and œdema of the neighboring parts, dyspnœa from the collection of

viscid mucus, which cannot be expelled through the wound, and emphysema.

He reports three cases in illustration of his method, all of which were successful, recovery ensuing in all but one, in which an insane subject reopened his own wound.

He dwells upon the necessity of securely fixing the head and steadying the neck during the healing of these wounds after closure by suture, and summarizes the advantages of his method as follows:

(1) The cut edges of each structure being brought into exact apposition, and so retained by the sutures, union by first intention is secured.

(2) This rapidity of union allows of rectal feeding being employed up to the time the patient can swallow naturally.

(3) The distress caused by feeding three or four times a day, through a tube passed into the pharynx or œsophagus, is thereby avoided.

(4) The prevention of painful or distressful attempts at swallowing, attended by the escape of the fluid at the wound, and the excitement of troublesome spasmodic cough.

(5) The prevention of the great risk of contraction or stricture of the air passage or food passage so likely to follow when the wounds have been allowed to heal by granulation.

(6) The prevention of a temporary or permanent fistula opening into the air or food passage.

(7) The avoidance of an *alleged* danger in cases where the epiglottis is cut through, viz., of suffocation from the detached portion of the epiglottis falling over the upper aperture of the larynx.—*London Lancet*, December 24, 1892.

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BONES-JOINTS, ORTHOPÆDIC.

I. The Later Results of Laminectomy for Paraplegia Due to Angular Curvature. By W. ARBUTHNOT LANE, M.S. (London). Of eleven cases operated on two terminated fatally.